DSHS – HRSA

Mental Health Division

HIPAA Rule 1 Data Gap Analysis

June 19, 2002

Prepared by:

Francine Kitchen, HIPAA Consultant

Table of Contents

Executive Summary 3
Overview 3
Results 3
Step 1. Identify Transactions 4
Step 2. Data Mapping 8
Step 3. Identify Gaps 9
Legacy Fields Too Short for HIPAA 9
270/271-Eligiblity Inquiry/Response From Providers 9
Match Back 9
276/277-Claim Status Inquiry/Response From Providers 10
HIPAA Required Fields with No Matching Legacy Field 10
Match Back 10
820-Premium Payment Outbound 10
HIPAA Required Fields with No Matching Legacy Field 10
Legacy Fields with No Place in HIPAA 11
834-Enrollment Inbound 11
Legacy Fields with No Place in HIPAA 11
Looping 11
Mandatory Code Sets 11
835-RA (A19) to AFRS 12
HIPAA Required Fields with No Matching Legacy Field 12
Match Back 12
837-Health Care Encounters from RSNs, Claims from CLIPs 12
Community Mental Health Hospitals Payment Summary 13
837I-Institutional Encounter 13
Legacy Fields with No Place in HIPAA 837I 14
835-RA 14
Legacy Fields with No Place in HIPAA 835 14

Executive Summary

Overview

Since all payers must support all electronic HIPAA transactions if they correspond to any of the payer's business processes, whether manual or electronic, MHD must support all HIPAA transactions (except Dental Claims). The purpose of HIPAA Data Gap Analysis is to identify detailed programming/field-level issues which need remediation in order for MHD to be HIPAA compliant. The steps to accomplish this include:

1. Identify the DSHS administrations' business processes that correspond to HIPAA transactions
2. Perform data mapping (comparisons) between HIPAA transactions and legacy records
3. Identify and document the HIPAA data analysis gaps

Results

22 business processes were identified for which data mapping should be done:

- 3 of these cannot be completed without knowing what the remediated MMIS records will be
- 8 of these use the State Mental Hospital's RPS system, which is being analyzed by Finance
- 11 of these have been mapped and the results are documented here

The major gaps identified are:

- **Longer lengths** are needed for 2 CIS fields to support HIPAA byte lengths.
- Several incoming HIPAA data elements must be **stored for use in outgoing** HIPAA response transactions.
- For **276/277-Claim Status Inquiry/Response** , 4 new fields must be added.
- For **820-Premium Payments**, 2 new fields must be added to AFRS, if AFRS will be performing this function for MHD.
- For **820-Premium Payments**, AFRS vendor number has no place to be sent .
- For **834-Enrolllment**, there's no place in HIPAA for sexual orientation or more than one disability diagnosis.
- For **834-Enrolllment**, there may not be adequate standard code values for race/ethnicity or language.
- For **837-Encounter**, HIPAA has only one place for diagnoses, while CIS has axis 1 and 2 for each diagnosis code.
- For **837-Encounter**, there's no place in HIPAA for community mental health hospitals to send date paid.

Step 1. Identify Transactions

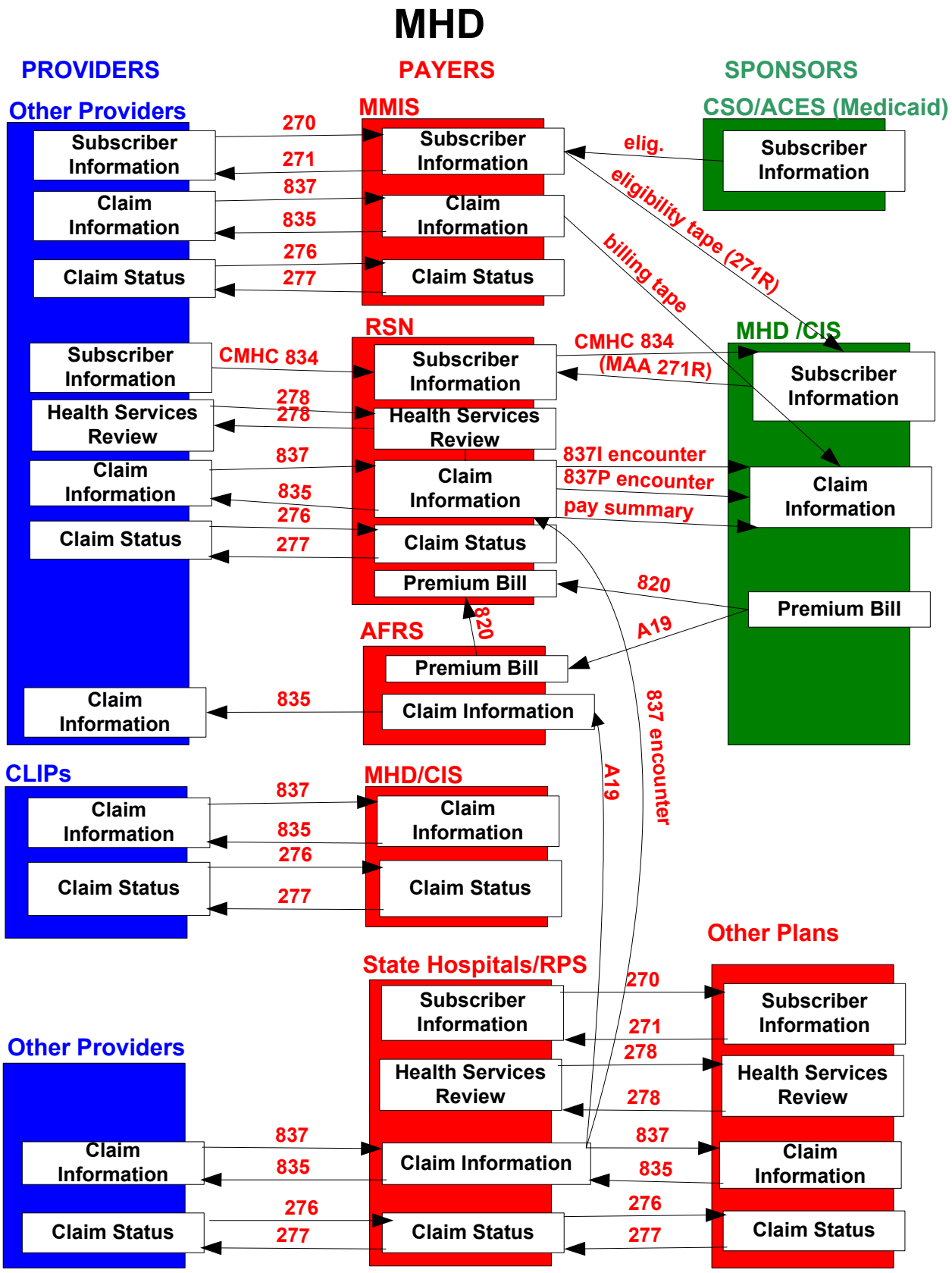
The first step is to identify which business processes must be HIPAA compliant, by comparing the HIPAA transactions (tx) descriptions with the business processes. This was partially accomplished by the Sierra business analysts and documented in their Deliverable I. Further refinement and HIPAA assessment has been done by Allen McCall in a report specifically for MHD dated February, 2002.

The following table and diagram are based upon Allen McCall's report and discussions with Ron Jennings. Some data mappings done are not necessarily for current business processes that must be HIPAA compliant. For example, at some point it is anticipated than an RSN will quit doing business with MHD, at which point MHD will have to support what an RSN currently does. Another example, is the claim and remittance between providers and state hospitals, which may or may not be HIPAA transactions because they are between two providers, not between a provider and a plan. In these cases the data mapping analysis was done just in case it might be needed.

	Transactions, Senders, Receivers	Comment	System	Mapping Report:
	MHD from MMIS:			
1	MHD elig file from MAA MMIS (roster)	not mandated	MMIS to CIS	(awaiting MMIS remediated records)
2	MHD billing tape (encounter) from MAA MMIS	not mandated	MMIS to CIS	(awaiting MMIS remediated records)
	MHD to/from RSNs/providers:			
3	MHD 820-premium to RSN (A19 to AFRS)		AFRS	HIPAA 820 to AFRS
4	MHD CMHC 834-enrollment from RSN: consumer demographics	not mandated	CIS	HIPAA 834 to MHD
5	MHD eligibility roster to RSN (from MMIS)	not mandated	CIS	(awaiting MMIS remediated records)
6	MHD 837I-Encounter from RSN: community hospital payment summary		CIS	HIPAA 837I to MHDch, HIPAA 835 to MHDch*
7	MHD 837I-Encounter from RSN: ET Inpatient Service		CIS	HIPAA 837I to MHD
8	MHD 837P-Encounter from RSN: Outpatient Service		CIS	HIPAA 837P to MHD
9	MHD 270/271-elig inquiry/response from prov	If MHD assumes RSN role	CIS	HIPAA 271 to MHD
10	MHD 837I-Encounter request/response from prov: community hospital authorization	If MHD assumes RSN role	CIS	HIPAA 837I to MHDau*
11	MHD 276/277-status inquiry/response from prov	If MHD assumes RSN role	CIS	HIPAA 277 to MHD
	MHD to/from CLIPs:			
12	MHD 837-claim from CLIP (A19+)		CIS	HIPAA 837I to MHD
13	MHD 835-RA to CLIPs (A19 to AFRS)		AFRS	HIPAA 835 to AFRS
14	MHD 276/277-status inquiry/response from CLIP for Medicaid children	phone now	CIS	HIPAA 277 to MHD

	Transactions, Senders, Receivers	Comment	System	Mapping Report:
	State Hospitals to/from plans:			
15	State Hospital 270/271-elig inquiry/response to plans		RPS	Being mapped by Finance
16	State Hospital 278-auth. request/response to plans	phone now	RPS	Being mapped by Finance
17	State Hospital 837-claim to plans		RPS	Being mapped by Finance
18	State Hospital 835-RA from plans		RPS	Being mapped by Finance
19	State Hospital 837-Encounter to plans		RPS	Being mapped by Finance
	State Hospitals to/from providers:			
20	State Hospital 837-claim from prov	not mandated	RPS	
21	State Hospital 835-RA to prov (A19 to AFRS)	not mandated	AFRS	HIPAA 835 to AFRS
22	State Hospital 276/277-status inquiry/response from prov	phone now	RPS	

* "MHDch" is a construct needed in the gap analysis tool to allow the same transaction, 837I, to be mapped two different ways: once for RSNs ("MHD") and once for community hospitals ("MHDch").


MHD
PROVIDERS
PAYERS
SPONSORS
Other Providers
MMIS
CSO/ACES (Medicaid)
Subscriber Information
Claim Information
Claim Status
270
271
837
835
276
277
elig.
eligibility tape (271R)
billing tape
RSN
MHD /CIS
CMHC 834
CMHC 834 (MAA 271R)
Health Services Review
278
837I encounter
837P encounter
pay summary
Premium Bill
820
A19
AFRS
CLIPs
MHD/CIS
837 encounter
Other Plans
State Hospitals/RPS

Step 2. Data Mapping

The second step of data gap analysis is to compare the HIPAA data elements to the legacy system data elements (fields). For example, if the administration's current information system will need to support a HIPAA claim status response, then it must contain a status code for each claim, because that is a required data element in the HIPAA transaction. The goal of data mapping is to identify:

- Any HIPAA required data elements that are not stored in the legacy system,
- Any legacy system data elements that have no place to be sent in the HIPAA transaction,
- Any legacy system data elements that need to be longer to support HIPAA byte lengths,

A similar analysis must be done to identify all local codes that must be converted to standard codes. That was the responsibility of the Local Codes TAG (lead by Katie Sullivan), and is beyond the scope of this data mapping project.

In order to achieve the above data mapping goals, the following tasks were completed:

1. Identify which legacy system data records (tables) contain the relevant data elements for each transaction.
2. Load the legacy record layout (fieldnames, data types, byte lengths) into the gap analysis software/tool.
3. Match all the legacy record fields to a place to be sent in the HIPAA transaction, based upon HIPAA implementation guides and discussions with legacy system data content experts.
4. Identify any HIPAA required data elements that are not stored in the legacy system.
5. Document any known special processing logic that will be needed to convert data during implementation.
6. Generate a report out of the gap analysis tool to document all of the above.

The mapping reports that were generated should be used not only for gap analysis, but also for implementation. The names of the MHD mapping reports are shown in the table in the previous section. They are viewable, along with other administrations' mapping reports, from the MAA Intranet at:

http://maaintra.dshs.wa.gov/DSHSHIPAA/mapping.asp

Step 3. Identify Gaps

This section lists all the data issues that should be addressed in order to comply with HIPAA Rule 1 for this administration, as well as is known based on discussions with administration representatives. Based on the data mapping described in the previous section, the following sections describe the data gaps discovered. In the following tables, "Transaction", "Loop", and "Segment" identify the position of the data elements within the HIPAA transactions.

Legacy Fields Too Short for HIPAA

The following legacy fields are shorter than the length of the corresponding HIPAA data elements. HIPAA Rule 1 mandates that no data be truncated. So if data is received via a HIPAA transaction that is longer than the current field where it should be stored, AND that data would ever need to be sent back out in another HIPAA transaction, then the longer length must be accommodated.

Trans-action	Loop	Segment	HIPAA Data Element	HIPAA Length	Legacy Field Name	Legacy Length
All	All	NM103	Subscriber/Patient/Member/Provider/ Receiver/Submitter Last or Organization Name	35	Consumer Demog, Surname	30
All	All	NM104	Provider First Name	25		
All	All	NM105	Subscriber/Patient/Member/Provider Middle First Name	25		
837/835	Claim	CLM01	Patient Account Number	38	Claim ID	20

270/271-Eligiblity Inquiry/Response From Providers

(Mapping Report: "HIPAA 271 to MHD")

A provider can ask a payer about the eligibility of a client using the HIPAA 270 transaction. The payer must respond with at least a yes/no whether the client is eligible using the HIPAA 271 transaction. The CLIP's may ask for the status from MHD. If MHD performs the RSN function in the future then it would also be used by other providers.

There are no data gaps in responding to an eligibility request, except for storing data from the request to use in the response.

Match Back

This data must be stored from the incoming request and returned in the response.

Loop	Segment	HIPAA Data Element
Info Recvr	NM1	Info Recvr Name and ID
Info Recvr	REF	Info Recvr Add'l ID
Info Recvr	TRN	Requestor's Trace Number

276/277-Claim Status Inquiry/Response From Providers

(Mapping Report: "HIPAA 277 to MHD")

A provider can ask a payer about the status of a claim using the HIPAA 276 transaction. The payer must respond with standard values of claim status codes using the HIPAA 277 transaction. This transaction would only be needed by MHD if an RSN quits, and MHD must take its place.

HIPAA Required Fields with No Matching Legacy Field

Loop	Segment	HIPAA Data Element	Legacy Field Name	Comment
Claim	STC01-1	Claim Status Category Code	None	Generate a standard code, see www.wpc-edi.com
Claim	STC01-2	Claim Status Code	None	Generate a standard code, see www.wpc-edi.com
Claim	STC04	Total Claim Charge Amount	None	
Claim	STC05	Claim Payment Amount	None	Zero if in process
Claim	STC09	Check or EFT Number	None	

Match Back

This data must be stored from the incoming request and returned in the response.

Loop	Segment	HIPAA Data Element	Comment
Information Receiver	NM1	Info Receiver Name and ID	
Service Provider	NM1	Service Provider Name and ID	
Claim	TRN	Submitter's Trace Number	
Claim	REF	Institutional Bill Type ID	Store from 276 or 837I

820-Premium Payment Outbound

(Mapping Report: "HIPAA 820 to AFRS")

A sponsor may be asked to send an electronic premium payment to a managed care provider organization using a HIPAA 820 transaction. MHD will need to send these to the RSNs.

HIPAA Required Fields with No Matching Legacy Field

Loop	Segment	HIPAA Data Element	Comment
			(req'd in 835, not 820)
			(req'd in 835, not 820)
Organiz. Summary	SLN04	Head Count	Need a count of number of members.
Indiv.	ENT04	Receiver's Individual ID	Get client's ID from attachment; ITEIP

Remit			doesn't have this.
Indiv. Remit	RMR05	Billed Premium Amount	Required if adjusting a previous premium, this is the previously-payed premium amount.

Legacy Fields with No Place in HIPAA

Loop	Segment	Legacy Field Name	Comment
Receiver	N104	VENDOR_NUMBER: MHD's ID for provider	Only One spot for either Fed.TaxID or vendor number; must choose one

Wendi Gunther says "most vendors use one tax ID although they may serve many different parts of the state/DSHS under several
different contracts. I would assume that if they were trying to find out about a certain payment, in order to answer any questions we would need to have more than the tax id."

834-Enrollment Inbound

(Mapping Report: "HIPAA 834 to MHD")

Community Mental Health Centers enroll clients and send electronic enrollments to MHD. This is not a mandatory HIPAA transaction, since it is not going from a sponsor to a payer. But MHD may want to receive a HIPAA 834 format with the data it currently gets. It is also quite possible that this data can continue to be sent in the current format. This can be negotiated between the trading partners.

Legacy Fields with No Place in HIPAA

Loop	Segment	Legacy Field Name	Comment
Member	None	Sexual Orientation	
Member	DSB07	Primary diagnosis, secondary diagnosis, impairment kind	Only one place for diagnosis

Looping

The HIPAA enrollment transaction allows an unlimited number of members in a repeating loop in each transaction. Whatever software parses it must be able to accommodate this.

Mandatory Code Sets

Following is a list of standard codes that must be supported.

Loop	Segment	HIPAA Data Element	Legacy Field Name	Comment
Member	INS08	Employment Status Code	Employment Status	Convert to valid HIPAA codes, Impl. Gde, p. 49
Member	DMG05	Race or Ethnicity Code	EthnCod, HispOrig, Race	Standard codes do not meet state reporting requirements

Member	LUI02	Language Code	LangCd	Didn't find local native languages in standard code set: double check
Member	DSB08	Disability Diagnosis Code	Impairment Kind	These disability codes must be converted to ICD9 diagnosis codes

835-RA (A19) to AFRS

(Mapping Report: "HIPAA 835 to AFRS")

A payer must be able to support sending electronic remittance advices. The current MHD A19 to AFRS must be converted somehow to a HIPAA 835 transaction. Middleware software could be used to store data elements from the incoming 837-claims transactions in order to populate the required fields in the 835-RA transaction.

HIPAA Required Fields with No Matching Legacy Field

Loop	Segment	HIPAA Data Element	Comment
Header	BPR07	Payer's Bank ID	Required if EFT
Header	BPR09	Payer's Bank Account Number	Required if EFT
Header	BPR13	Payee's DFI Bank ID	Required if EFT
Header	BPR15	Payee's bank account number	Required if EFT

Match Back

This data must be stored from the incoming request (claim) and returned in the response (RA).

Loop	Segment	HIPAA Data Element	Comment
Header	REF02	Receiver ID	
Claim	CLP01	Patient Account Number	Provider's ID for client
Claim	NM1	Patient Name (Last, First) and ID	
Service	SVC01-2	Procedure Code and modifiers	HCPCS Code

837-Health Care Encounters from RSNs, Claims from CLIPs

(Mapping Report: "HIPAA 837I to MHD" and "HIPAA 837P to MHD" and "HIPAA 837I to MHDau")

A payer must be able to receive electronic claims/encounters. The claim and encounter transactions are the same in HIPAA. The "institutional" (as opposed to "professional") claim transaction is intended for billing any hospital services, even if the visit was only for an hour. MHD will receive electronic encounters from the RSNs for all types of health care services, both hospital and professional, both inpatient and outpatient. Three separate data mappings have been created for the HIPAA institutional encounters (837I) and professional encounters (837P). But since the gaps are the same the following summary applies to both. The mapping and

analysis for the CLIP 837I claim and for the Community Hospital Authorization is the same as for the 837I encounter.

Since MHD is receiving this transaction, rather than sending it, MHD doesn't have to worry about not storing all required fields. For a list of incoming 837 fields that need to be sent back in the corresponding 835-RA, see the section for 835 (Match Back list).

ICD9 Diagnosis Codes

Loop	Segment	HIPAA Data Element	Legacy Field Name	Comment
Claim	HI	Principal Diagnosis	ET Inpatient Services, Primary Diagnosis Axis 1	Only one place in HIPAA for primary diagnosis code
Claim	HI	Principal Diagnosis	ET Inpatient Services, Primary Diagnosis Axis 2	No place for "axis 2"; is it concatenated with "axis 1" to form the full ICD9 code?
Claim	HI	Other Diagnoses	ET Inpatient Services, Secondary Diagnosis Axis 1	Only one place in HIPAA for secondary diagnosis code
Claim	HI	Other Diagnoses	ET Inpatient Services, Secondary Diagnosis Axis 2	No place for "axis 2"; is it concatenated with "axis 1" to form the full ICD9 code?

Looping

HIPAA transaction formats contain complex looping structures to allow repetition of sets of related data. The software that parses the incoming 837 transaction will need to accommodate optionally:

- Many billing providers in one transaction (no upper limit),
- Many clients for each billing provider (no upper limit),
- Up to 100 claims for each client,
- Up to 999 service line items for each claim (50 for professional).

Community Mental Health Hospitals Payment Summary

(Mapping Report: "HIPAA 837I to MHDch" and "HIPAA 835 to MHDch")

Two separate data mappings were done for the Community Mental Health Hospitals payment summary. This transaction is thought of as an encounter by MHD currently. HIPAA provides the 837 transaction for sending encounter data from a payer to a sponsor, but it has no place to send payment amount and date paid which are in the current payment summary legacy transaction. On the other hand, the 835-RA HIPAA transaction can accommodate date paid but not all other legacy fields. But sending an 835 from a payer to a sponsor is not a mandated HIPAA transaction. There is nothing forbidding a payer from sending a copy of an 835 to a sponsor, however. How this data is sent from the RSNs to MHD must be negotiated in a trading partner agreement.

837I-Institutional Encounter

If the community hospital payment summary is mapped to a HIPAA 837I, the following gaps will exist:

Legacy Fields with No Place in HIPAA 837I

Loop	Segment	Legacy Field Name	Comment
Claim	AMT02	Reimbursement Amount	Might be able to put it in HIPAA **Estimated** Claim Due Amount?
		Date Paid	No place in HIPAA

835-RA

If the community hospital payment summary is mapped to a HIPAA 835, the following gaps will exist:

Legacy Fields with No Place in HIPAA 835

Loop	Segment	Legacy Field Name
Claim	None	Diagnosis ICD9 codes
Claim	None	Legal Status
Claim	None	TPL Amount
Claim	None	MediCare Amount